CENTER FOR HEALTH INFORMATION AND ANALYSIS

Data Specification Manual

957 CMR 2.00: Payer Reporting of Relative Prices

August 20, 2021

957 CMR 2.00
Payer Reporting of Relative Prices
Data Specification Manual

Contents

1. SUMMARY OF CHANGES 2
2. INTRODUCTION 3
3. FILE SUBMISSION INSTRUCTIONS & SCHEDULE 3
4. IDENTIFICATION OF PROVIDERS 5
5. PAYER REPORTING GUIDELINES 6
   - DEFINITIONS 6
   - FILE LAYOUTS 7

APPENDIX A: UNIFORM RELATIVE PRICE PROVIDER LIST 11
APPENDIX B: RP CALCULATION EXAMPLES 12
APPENDIX C: NON-CLAIMS PAYMENT ALLOCATION METHODOLOGY 13
APPENDIX D: DATA SUBMISSION GUIDELINES 17
APPENDIX E: REFERENCE TABLES 23
APPENDIX F: SUBMISSION NAMING CONVENTIONS 27
APPENDIX G: REPORTING NON-CLAIMS PAYMENTS IN HOSPITAL OUTPATIENT, PHYSICIAN GROUP, AND OTHER PROVIDER FILES 28

1. Summary of Changes

- Physician Group data will be collected for 2020 and 2021 for this year's submission.
- The reporting thresholds for providers have changed:
    - Physician Groups reported must represent at least 90% of total physician payments.
    - Other Providers reported must represent at least 80% of total payments for each provider type.
        - Relative Price thresholds for calculation has increased to $20,000 for both Physician Groups and Other Providers.
            - ***Providers that are under this threshold still need to be reported within the aggregate codes in order to accurately calculate the network averages for each payer***
- Payers are asked to provide a breakdown of payments to in-network vs. out-of-network providers

2. Introduction

M.G.L. c. 12C, § 8 requires the Center for Health Information and Analysis (CHIA) to "publicly report relative prices, as newly defined in Section 1 as contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer's network-wide average amount paid to providers."

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to calculate and report these data to CHIA. The Data Specification Manual provides additional technical details to assist payers in reporting and filing these data.

Payers are required to submit three Relative Price (RP) files to CHIA annually. The files will contain hospital data for the previous calendar year, physician group data for the calendar year ending seventeen months prior, and other provider data for the previous calendar year. Files can only contain data for one year. Files will contain:

a. Payer comments (in all files)
b. Separate RP data with distinct lines for Medicare Advantage; Medicaid and Medicaid Managed Care Organization (MCO); Commercial (self and fully insured); Medicare and Medicaid Dual-Eligibles, aged 65 and over; and Medicare and Medicaid Dual-Eligibles, Aged 21-64, by:
    - Acute hospital inpatient
    - Acute hospital outpatient
    - Psychiatric hospital inpatient, including behavioral health data for acute hospitals with psychiatric care or substance abuse units
    - Psychiatric hospital outpatient, including behavioral health data for acute hospitals with psychiatric care or substance abuse units
    - Chronic hospital inpatient
    - Chronic hospital outpatient
    - Rehabilitation hospital inpatient
    - Rehabilitation hospital outpatient
    - Physician group practices
    - Ambulatory surgical centers
    - Community health centers
    - Community mental health centers
    - Freestanding clinical labs
    - Freestanding diagnostic imaging
    - Home health agencies
    - Skilled nursing facilities

Please see Appendix F of this document for information regarding file naming conventions for hospital and non-hospital RP data files, layout specifications, and field definitions.

3. File Submission Instructions & Schedule

Payers will submit RP data via CHIA Submissions[1] in a Microsoft Excel file template provided by CHIA. The template will be available to download on CHIA's website at http://www.chiamass.gov/payer-data-reporting-relative-price-rp/. Payers must enter the data in the appropriate columns of the Data tabs in the template. After entering the data, payers must click the Data Review button on the Front Page tab. This will verify the data entered and allow for review prior to submission.

In 2021, payers will submit four RP files to CHIA. The 'HOS' notation will apply to hospital relative price files, the 'PG' notation will apply to the physician group relative price file for years 2019 and 2020, and the 'OP' notation will apply to the other provider relative price file. HOS files must contain only hospital record types. PG and OP files must contain only physician and other provider record types, respectively. If the record types reported in the file do not match the specific template, the file will not be accepted for submission. The file naming convention will be auto-generated by the "Save and Name Submission" button on the Front Page tab. If this format is not used, the file will not be accepted for submission. Please see the last page of this document for complete file naming instructions.

The Front Page tab requires metadata information for the file and contains two fields for payer comments. The "RP Comments" field allows payers to explain any data nuances or other issues that they wish to disclose to CHIA, while the "additional comments" field allows payers extra space for explanatory information. For instance, if the payer's reimbursement method differs by insurance category, the payer must note the standard payment unit used for each insurance category. The payment unit used must be uniform within each insurance category. Additionally, data submitters must acknowledge that the data reviews have been completed and that the data is correct.

Payers will submit RP information in accordance with regulation 957 CMR 2.00, on the following schedule:

Relative Prices Filing Schedule	
Date	**Files Due**
Friday, August 20, 2021	Requested additions to the uniform relative price provider list
Friday, October 1, 2021 Wednesday, October 6, 2021 Friday, October 15, 2021 Friday, October 15, 2021 Friday, November 5, 2021	CY 20 Hospital Relative Prices Multiplier Calculation Summary CY 19 Physician Group Relative Prices CY 20 Physician Group Relative Prices CY 20 Other Provider Relative Prices

Upon receipt of a payer's RP data file, CHIA will review the data file and provide a summary report back to the payer. After analyzing the submission for data quality, CHIA will provide another report and a verification form to the payers. After reviewing this report, a payer's Chief Financial Officer or equivalent must sign and return the data verification statement within five business days. A payer's filing is not complete until the data verification statement has been received by the Center.

[1] For more information on CHIA Submissions, including registration forms and submission instructions, please see CHIA website (http://chiamass.gov/information-for-data-submitters-payer-data-reporting/).

4. Identification of Providers

Payers must report RP data for Massachusetts-based providers who were reimbursed for member care and payments that exceed the reporting threshold. Payers should include payments data for non-Massachusetts members if they seek care at a Massachusetts provider. CHIA has included a uniform provider list within the data submission template for reference. In addition, CHIA has also published the uniform provider list on its website for the most commonly reported provider groups. The link to the list may be found in Appendix A. Payers are required to use this uniform relative price provider list and CHIA OrgIDs for RP reporting. If the payer contracts with a provider that is not included on the provider list, the payer should submit a request to CHIA to have the provider added. The file submission will not be accepted if data is included for providers that are not on the provider list.

In addition, payers must report providers in accordance with the provider type identified in the uniform relative price provider list, e.g. physician groups must be reported in the PG file, home health agencies must be reported in the OP file, etc. Note that the provider and provider type relationship is mutually exclusive, with the exception of acute hospitals licensed with separate psychiatric units. **Providers reported that do not align with the provider OrgID and provider type identified in the uniform relative price provider list will not be accepted for submission.** Data submitters should review the uniform provider list, and submit any requests for additions or updates to CHIA by September 22, 2021. Requests can be emailed to Brian Danner at Brian.Danner@chiamass.gov.

For professional services and physician groups, payers are to report the top organizations based on share of total payments, according to their contractual relationships. These top organizations should be based upon payments to the parent provider, and should be reported until at least 90% of total payments to all physician groups are represented, or payments to a parent provider group are less than $20,000. Payers shall report all remaining physician group payments in aggregate under OrgID 999998 for aggregate physicians not paid on a fee schedule, or OrgID 999999 for aggregate physicians paid on a fee schedule.

For all other provider types, payers are to report the top providers based on share of total payments, according to their contractual relationships, until at least 80% of total payments to all providers within each provider type have been represented in the reported providers. Payers must report aggregate data for other health care providers for that provider type. Payers must use the appropriate organization type OrgID as listed below when reporting aggregate data for Other Providers and providers with payments less than $20,000. CHIA may request additional information on these providers.

Aggregate Organization Type	OrgID
Freestanding Ambulatory Surgical Centers	999901
Community Health Centers	999902
Community Mental Health Centers	999903
Freestanding Clinical Laboratories	999904
Freestanding Diagnostic Imaging Centers	999905
Home Health Agencies	999906
Skilled Nursing Facilities	999907

5. Payer Reporting Guidelines

Payers must report RP data for the specified providers by insurance category (Medicare Advantage; Medicaid; commercial insurance; Dual-Eligibles, 65 and over; Dual-Eligibles, 21-64; and Other) and by product type (HMO and POS, PPO, Indemnity, and Other). (See Appendix E, Tables A and B.) The RP data submission includes information regarding claims and non-claims payments by product and service.

- **Definitions**

Claims Payments. Claims payments include all payments made pursuant to the payer's contract with a provider made on the basis of a claim for medical services, including patient cost-sharing amounts. Reported values for a particular provider should reflect only payments made for services delivered by that provider. For example, if a physician group is reimbursed using global capitation based on a comprehensive set of services, claims payments should capture only physician group services, and not the full spectrum of services provided to patients under such contracts.

Non-Claims Payments. Non-claims payments include all payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services. Only payments made to providers should be reported. Payments to government entities, such as the Health Safety Net Surcharge, should be omitted.

Payers must report non-claims payments for each provider, service setting (hospital inpatient, hospital outpatient, and professional services) by insurance category and by product type. Non-claims payments may be "specified" or "non-specified." Specified payments are payments that are directly attributable to a provider, service setting, insurance category, and product type; for example, a performance bonus paid to a hospital for inpatient services for Medicare Advantage HMO plans. Non-specified payments are payments that are only attributable in part to a provider, service setting, insurance category and product type; for example, a performance bonus paid to a hospital, but not otherwise specified for a given product or patient population at that hospital. Payers must report the specified payment amounts whenever these data are available. For the balance of non-specified payments, payers must allocate on the basis of percentage of claims payments. Non-claims payments made to hospital systems or provider groups as a whole must be allocated to each hospital (inpatient and outpatient individually) or physician local practice group according to the claims payments made to the entities as a percent of total claims payments. (Please see the example in Appendix C for further detail.)

In the RP submission, payers will only report the final non-claims amount (specified plus non-specified) for each provider, insurance category, and product type combination. If payers allocate non-claims payments to individual services by an internal methodology, then the non-claims payments should be reported in that allocation. If payers do not allocate non-claims payments, then non-claims should be entered as its own service category. See Appendix G for further details on how to report non-claims payments. CHIA may request additional detail regarding non-claims payment allocation.

- **File Layouts**

a.) Hospital Inpatient

Hospital inpatient data will be reported in the Hos Inpatient Data tab of the Hospital RP Template, separately identified by hospital type (acute, psychiatric/substance abuse, chronic, rehabilitation (see Appendix E, Table C). Payers must report total number of discharges, total claims payments, total non-claims payments and case mix.

Payers must submit additional behavioral health-only RP data for acute hospitals with psychiatric or substance abuse units. For such acute hospitals, the payer will report data for the same hospital twice: once as an acute hospital type, submitting data for all services including behavioral health, and again as a psychiatric hospital type, submitting behavioral health data only.

CHIA will calculate the following fields based on the data submitted by the payer:

1. Product-Specific Adjusted Base Rate. The sum of total claims and non-claims payments divided by the sum of the products of case mix scores and discharges (CMADs). This base rate is computed separately for each product type.

2. Network Average Product Mix. Percentage of total network payments attributed to each product type.[2]

3. Hospital Product-Adjusted Base Rate. The sum of the products of the adjusted base rates for each product type and the corresponding network average product mixes.

4. Network Average Hospital Product-Adjusted Base Rate. Simple average of Hospital Product-Adjusted Base Rates across all hospitals within a network.

5. Hospital Inpatient Relative Price. The hospital's product-adjusted base rate divided by the network average hospital product-adjusted base rate within each insurance category.

See Appendix B for RP Calculation examples.

b.) Hospital outpatient, physician group, and other provider

For the hospital outpatient, physician group, and other provider file types, payers must submit provider-specific service multipliers (service categories to be determined by the payer), total claims-based payments, total non-claims payments, and provider-specific service payments. HOS outpatient data will be reported in the Hos Outpatient Data tab of the Hospital RP Template, while PG data will be reported in the Physician

[2] A network is defined by each provider type-insurance category combination (e.g., Acute Hospital inpatient-Commercial, or Skilled Nursing Facility-Medicare Advantage).

Group Data tab of the Physician Group RP Template and OP data will be submitted in the Other Provider Data tab of the Other Provider RP Template.

Provider-Specific Service Multipliers. Provider-specific service multipliers are the negotiated service-specific mark-up from the standard fee schedule, reported for each provider, by insurance category and product type. The service multipliers must be defined for each service type for which payers reimburse providers for. Payers must provide negotiated multipliers directly from the contract wherever feasible. In this case, the "MultiplierIndicator" field would be designated as 1 = Negotiated base rate or multiplier (not calculated).

If it is not possible to provide negotiated multipliers directly from the contract then an alternative approach is the indirect standardization method shown below. In this case, the "MultiplierIndicator" would be designated as 2 = Calculated payment-derived base rate or multiplier.

This method relies on claims-based payments and number of units for the services being analyzed. For example, for lab/radiology and emergency department services, the data could be grouped by CPT code. For ambulatory surgery services, when reimbursement is negotiated by ambulatory surgery categories using case rates, the data could be grouped by these case rate categories. The resulting multiplier is based on comparing a provider's "actual" average price to its "expected" average price. The expected average price is calculated using the network average prices for each case rate or CPT code. The example shown below is a hypothetical calculation of multipliers for lab services. In this example, there are only two providers in the network and two CPT codes that make up lab services, CPT X and CPT Y.

	(1)	(2)	(3)	(4)	(5) = (1)/(3)	(6) = (2)/(4)	(7)	(8)	(9) = (7)/(8)
Lab Services Multiplier	**CPT X Total Allowed Claims**	**CPT Y Total Allowed Claims**	**CPT X Units**	**CPT Y Units**	**CPT X Price**	**CPT Y Price**	**Actual Average Price**	**Expected Price**	**Multiplier = Actual/Expected**
Provider A	$250	$300	3	3	$83.33	$100.00	$91.67	$78.21	1.172
Provider B	$700	$700	10	9	$70.00	$77.78	$73.68	$77.94	0.945
Total/Network Average	$950	$1,000	13	12	$73.08	$83.33			

Columns (1) & (2): These represent total allowed claims paid out for CPT X and CPT Y for Provider A & B in a given year.

Columns (3) & (4): These represent total units for CPT X and CPT Y for Provider A & B for the same year as the reported allowed claims.

Column (5) & (6): These represent an imputed price for CPT X and CPT Y by provider and for the network.

Column (7): This is the actual price across both CPT codes. The formula for Provider A is: ($250+$300)/ (3+3) = $91.67. The formula for Provider B across both CPT codes is: ($700 + $700)/ (10+9) = $73.68

Column (8): This is the expected price for each provider using the network average prices. The formula for Provider A is {(3*73.08+(3*83.33)}/ (3+3) = 78.21. The formula for Provider B is {(10*73.08) + (9*83.33)}/ (10+9) = $77.94

Column (9): This is the imputed multiplier and takes the ratio of Actual Price to Expected Price.

If it is not possible to provide negotiated multipliers directly from the contracts, and data are not available to use the indirect standardization method shown above, then it is expected that the carriers use their best judgment and available data to calculate multipliers by provider group and service category that reasonably represent the relative difference in price. In this case, the "MultiplierIndicator" would be designated as 2 = Calculated payment-derived base rate or multiplier.

The following fields will be calculated by CHIA.

1. Network Average Service Mix. Percentages of total network claims payments attributed to each service category.

2. Base Service-Weighted Multiplier. The sum of the products of each service multiplier and the network average service mix for each product type.

3. Network Average Product Mix. Percentages of total network claims payments attributed to each product type.

4. Base Service- and Product-Adjusted Multiplier. The sum of the products of the base service-weighted multipliers for each product and the corresponding network average product mix.

5. Non-Claims Multiplier. Total non-claims payments divided by total claims payments for each product type, multiplied by the base service-weighted multiplier for the corresponding product type.

6. Product-Adjusted Non-Claims Multiplier. The sum of the products of the non-claims multiplier for each product type and the corresponding network average product mix.

7. Adjusted Rate. The sum of the base service- and product-adjusted multiplier and the product-adjusted non-claims multiplier.

8. Network Average Adjusted Rate. Simple average of Adjusted Rates within a network.

9. Relative Price. For each provider, the provider-specific adjusted rate divided by the network average adjusted rate.

c.) Submitting the Template

The new Excel-based Relative Price templates include built in data validations. After inputting the data, users are required to run the data checks by clicking the Data Review buttons on the template Front Page tabs. If any errors are identified, users must correct these prior to submission. Users must also complete Table A.3 on the Front Page tab. If this table is not completed or if errors have not been corrected prior to submission, the submission will not be accepted by CHIA. For more information on how to use the template, please refer to the **RP Template User Guide** document.

When the template is completed, payers must submit the data via the CHIA Submissions web portal. For more information on CHIA Submissions, please see the FAQ section of the "Information for Data Submitters" page on CHIA's website.

Appendix A: Uniform Relative Price Provider List

In addition to the Uniform Relative Price Provider List posted on CHIA's website, the Provider List for each provider type is also included in the Relative Price Submission Template for each file type

Appendix B: RP Calculation Example

Appendix C: Non-Claims Payment Allocation Methodology

Total Non-Claims Payments	$10,000,000
Non-Claims Payments Specified for System X Hospital Inpatient	$6,000,000
Non-Claims Payments Specified for System X Hospital Outpatient	$ -
Non-Claims Payments Specified for System X Professional Services	$ -
Non-Specified Claims Payments to System X	$4,000,000

	Total Claims Paid	Claims-Based Distribution	Specified Non-Claims Payment	Allocation of Claims for Non-Specified Non-Claims Payments	Non-Specified Non-Claims	Total Payments
System X Hospital Inpatient	$150,000,000	50%	$6,000,000	50%	$2,000,000	$158,000,000
System X Hospital Outpatient	$125,000,000	42%		42%	$1,667,666	$126,666,667
System X Professional Services	$25,000,000	8%		8%	$333,333	$25,333,333

Allocation of Non-Claims Payments by Insurance Category

Hospital Inpatient Insurance Category Allocation

Insurance Category	Total Claims Paid for Basis of Allocation	Allocation of Specified Non-Claims Payments	Specified Non-Claims Payment	Allocation of Non-Specified Non-Claims Payments (claims-based distribution)	Non-Specified Non-Claims Payments	Total Payments
Medicare	$57,000,000	33%	$1,980,000	38%	$750,000	$59,730,000
Medicaid	$22,500,000	25%	$1,500,000	15%	$300,000	$24,300,000
Commonwealth Care	$9,000,000	42%	$2,520,000	6%	$125,000	$11,645,000
Commercial	$61,500,000	0%	$0	41%	$825,000	$62,325,000
Total for all Insurance Categories with Specified Non-Claims Allocation			**$6,000,000**			
Total for all Insurance Categories with Non-Specified Non-Claims Allocation					**$2,000,000**	
Overall Total	**$150,000,000**		**$6,000,000**		**$2,000,000**	**$158,000,000**

MEDICARE:

Allocation of Specified Non-Claims Payments

Hospital Inpatient Product Allocation

Product Type	Total Claims	Distribution of Specified Non-Claims Payments	Specified Non-Claims Payments
HMO and POS	$22,800,000	40%	$792,000
PPO	$19,950,000	35%	$693,000
Indemnity	$11,400,000	20%	$396,000
Other	$2,850,000	5%	$99,000
Total	**$57,000,000**		**$1,980,000**

Allocation of Non-Specified Non-Claims Payments

Hospital Inpatient Product Allocation

Product Type	Total Claims	Distribution	Allocation of Non-Specified Non-Claims Payments
HMO and POS	$22,800,000	40%	$300,000
PPO	$19,950,000	35%	$262,000
Indemnity	$11,400,000	20%	$150,000
Other	$2,850,000	5%	$38,000
Total	**$57,000,000**		**$750,000**

Hospital Outpatient Product Allocation

Product Type	Total Claims	Distribution	Allocation of Non-Specified Non-Claims Payments
HMO and POS	$11,250,000	30%	$150,090
PPO	$15,000,000	40%	$200,120
Indemnity	$6,750,000	18%	$90,054
Other	$4,500,000	12%	$60,036
Total	**$37,500,000**		**$500,300**

Professional Services Product Allocation

Product Type	Total Claims	Distribution	Allocation of Non-Specified Non-Claims Payments
HMO and POS	$3,000,000	40%	$40,000
PPO	$2,250,000	30%	$30,000
Indemnity	$1,500,000	20%	$20,000
Other	$750,000	10%	$10,000
Total	**$7,500,000**		**$100,000**

Appendix D: Data Submission Guidelines

File	Tab	Col	Data Element Name	Date Active (version)	Type	Format	Required	Element Submission Guideline
HOS	Hos Inpatient Data	A	Hospital OrgID	05/04/2020	Integer	########	Yes	The ORGID assigned by CHIA for the provider. Refer to Hospital List tab for the number associated with each provider Must be a CHIA-issued OrgID.
HOS	Hos Inpatient Data	B	Hospital Type Code	05/04/2020	Integer	#	Yes	Hospital Type. See Table E.1 on the Reference Tables tab.
HOS	Hos Inpatient Data	C	Insurance Category Code	05/04/2020	Integer	#	Yes	Insurance Category. See Table E.2 on the Reference Tables tab.
HOS	Hos Inpatient Data	D	Product Type Code	05/04/2020	Integer	#	Yes	Product Type. See Table E.3 on the Reference Tables tab.
HOS	Hos Inpatient Data	E	Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Claims Related Payments for every Hospital/Hospital Type/Insurance Category/Product Type combination. No negative values.
HOS	Hos Inpatient Data	F	NonClaims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Non-Claims Related Payments for every Hospital/Hospital Type/Insurance Category/Product Type combination.
HOS	Hos Inpatient Data	G	Discharges	05/04/2020	Integer	#########	Yes	Total Number of Discharges No negative values.
HOS	Hos Inpatient Data	H	Case Mix Score	05/04/2020	Number	##.##	Yes	Case Mix Index for all cases Value must be positive, and between '.2' and '10'.

File	Tab	Col	Data Element Name	Date Active (version)	Type	Format	Required	Element Submission Guideline
								NOTE: If case mix adjustment is not done for a given hospital type, then a 1 should be used for all case mix scores and situation should be noted in Front Page tab.
HOS	Hos Outpatient Data	A	Hospital OrgID	05/04/2020	Integer	########	Yes	The ORGID assigned by CHIA for the provider. Refer to Hospital List tab for the number associated with each provider Must be a CHIA-issued OrgID.
HOS	Hos Outpatient Data	B	Hospital Type Code	05/04/2020	Integer	#	Yes	Hospital Type. See Table E.1 on the Reference Tables tab.
HOS	Hos Outpatient Data	C	Insurance Category Code	05/04/2020	Integer	#	Yes	Insurance Category. See Table E.2 on the Reference Tables tab.
HOS	Hos Outpatient Data	D	Product Type Code	05/04/2020	Integer	#	Yes	Product Type. See Table E.3 on the Reference Tables tab.
HOS	Hos Outpatient Data	E	Service Category Code	07/19/2021	Integer	#	Yes	Service Category. See Table E.5 on the Reference Tables tab.
HOS	Hos Outpatient Data	F	Service	05/04/2020	Text	Free Text	Yes	A unique description describing the service group.
HOS	Hos Outpatient Data	G	Multiplier Indicator	05/04/2020	Integer	#	Yes	Payment Derived Service Multiplier Indicator. For every Hospital/Hospital Type/Insurance Category/Product Type/Service combination there can only be one Multiplier Indicator value.

File	Tab	Col	Data Element Name	Date Active (version)	Type	Format	Required	Element Submission Guideline
								See Table E.4 on the Reference Tables tab.
HOS	Hos Outpatient Data	H	Multiplier	05/04/2020	Number	##.##	Yes	Payment Derived Service Multiplier Indicator. For every Hospital/Hospital Type/Insurance Category/Product Type/Service combination there can only be one Multiplier Indicator value. Multiplier value must fall in range: '0.1'-'20'
HOS	Hos Outpatient Data	I	Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Claims Related Payments for every Hospital/Hospital Type/Insurance Category/Product Type/Service combination. No negative values.
HOS	Hos Outpatient Data	J	Non Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Non-Claims Related Payments for every Hospital/Hospital Type/Insurance Category/Product Type/Service combination.
PG	Physician Group Data	A	Provider Group OrgID	05/04/2020	Integer	########	Yes	The ORGID assigned by CHIA for the provider. Refer to Physician Group List tab for the number associated with each provider Must be a CHIA-issued OrgID.
PG	Physician Group Data	B	Local Practice OrgID	05/04/2020	Integer	########	Yes	The ORGID assigned by CHIA for the provider. Refer to Physician Group List tab for the number associated with each provider Must be a CHIA-issued OrgID.
PG	Physician Group Data	C	Insurance Category Code	05/04/2020	Integer	#	Yes	Insurance Category. See Table D.2 on the Reference Tables tab.

File	Tab	Col	Data Element Name	Date Active (version)	Type	Format	Required	Element Submission Guideline
PG	Physician Group Data	D	Product Type Code	05/04/2020	Integer	#	Yes	Product Type. See Table D.3 on the Reference Tables tab.
PG	Physician Group Data	E	Pediatric Indicator	05/04/2020	Integer	#	Yes	An indicator variable to mark that the physician group serves primarily pediatric patients: 0 = Non-Pediatric; 1 = Pediatric
PG	Physician Group Data	F	Service Category Code	07/29/2021	Integer	#	Yes	Service Category. See Table D.5 on the Reference Tables tab.
PG	Physician Group Data	G	Service	05/04/2020	Text	Free Text	Yes	A unique description describing the service group.
PG	Physician Group Data	H	Multiplier Indicator	05/04/2020	Integer	#	Yes	Payment Derived Service Multiplier Indicator. For every Provider Group/Local Practice Group/Insurance Category/Product Type/Service combination there can only be one Multiplier Indicator value. See Table D.4 on the Reference Tables tab.
PG	Physician Group Data	I	Multiplier	05/04/2020	Number	##.##	Yes	Payment Derived Service Multiplier Indicator. For every Provider Group/Local Practice Group /Insurance Category/Product Type/Service combination there can only be one Multiplier Indicator value. Multiplier value must fall in range: ‘0.1’-‘20’
PG	Physician Group Data	J	Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Claims Related Payments for every Provider Group/Local Practice Group/Insurance

File	Tab	Col	Data Element Name	Date Active (version)	Type	Format	Required	Element Submission Guideline
								Category/Product Type/Service combination. No negative values.
PG	Physician Group Data	K	Non Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Non-Claims Related Payments for every Provider Group/Local Practice Group/Insurance Category/Product Type/Service combination.
OP	Other Provider Data	A	Provider Group OrgID	05/04/2020	Integer	########	Yes	The ORGID assigned by CHIA for the provider. Refer to Physician Group List tab for the number associated with each provider Must be a CHIA-issued OrgID.
OP	Other Provider Data	B	Local Practice OrgID	05/04/2020	Integer	########	Yes	The ORGID assigned by CHIA for the provider. Refer to Physician Group List tab for the number associated with each provider Must be a CHIA-issued OrgID.
OP	Other Provider Data	C	Insurance Category Code	05/04/2020	Integer	#	Yes	Insurance Category. See Table D.2 on the Reference Tables tab.
OP	Other Provider Data	D	Product Type Code	05/04/2020	Integer	#	Yes	Product Type. See Table D.3 on the Reference Tables tab.
OP	Other Provider Data	E	Service Category Code	07/19/2021	Integer	#	Yes	Service Category. See Table D.5 on the Reference Tables tab.
OP	Other Provider Data	F	Service	05/04/2020	Text	Free Text	Yes	A unique description describing the service group.

File	Tab	Col	Data Element Name	Date Active (version)	Type	Format	Required	Element Submission Guideline
OP	Other Provider Data	G	Multiplier Indicator	05/04/2020	Integer	#	Yes	Payment Derived Service Multiplier Indicator. For every Provider Group/Local Practice Group/Insurance Category/Product Type/Service combination there can only be one Multiplier Indicator value. See Table D.4 on the Reference Tables tab.
OP	Other Provider Data	H	Multiplier	05/04/2020	Number	##.##	Yes	Payment Derived Service Multiplier Indicator. For every Provider Group/Local Practice Group/Insurance Category/Product Type/Service combination there can only be one Multiplier Indicator value. Multiplier value must fall in range: '0.1'-'20'
OP	Other Provider Data	I	Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Claims Related Payments for every Provider Group/Local Practice Group/Insurance Category/Product Type/Service combination. No negative values.
OP	Other Provider Data	J	Non Claims Payments	05/04/2020	Number	#######.##	Yes	The sum of all Non-Claims Related Payments for every Provider Group/Local Practice Group/Insurance Category/Product Type/Service combination.

Appendix E: Reference Tables

Table A: Insurance Category

ID	Description
1	Medicare Advantage
2	Medicaid
3	Commercial (self and fully insured)
4	Dual-Eligible, 65 and over
5	Dual-Eligible, 21-64
6	Other

Table B: Product Type

ID	Description
1	HMO and POS
2	PPO
3	Indemnity
4	Other

Table C: Hospital Type

ID	Description
1	Acute Hospital
2	Psychiatric or Substance Abuse Hospital or Acute Hospital Behavioral Health only
3	Chronic Hospital
4	Rehabilitation Hospital

Table D: Base Rate and Service Multiplier Indicator

ID	Description
1	Negotiated base rate or multiplier (not calculated)
2	Calculated payment-derived base rate or multiplier
3	Standard per unit rate (use for hospital inpatient only – non-acute hospitals or acute hospitals with waiver)

Table E: Organization Type

ID	Description
1	Hospital
2	Physician Group
3	Ambulatory Surgical Center
4	Community Health Center
5	Community Mental Health Center
6	Freestanding Clinical Labs
7	Freestanding Diagnostic Imaging
8	Home Health Agencies
9	Skilled Nursing Facilities

Table F: File Record Legend

File Field	Description
HOS	Hospital RP Template
PG	Physician Group RP Template
OP	Other Provider RP Template

Table G: Service Category Code for Hospital Outpatient

Service Category	Description
C01	Evaluation & Management Services
C02	Anesthesia Services
C03	Surgery
C04	Radiology Services
C05	Pathology and Laboratory Services
C06	Medical Services and Procedures
H01	Whole Blood
H02	Medical Care
H03	Surgery
H04	Consultation
H05	Diagnostic Radiology
H06	Diagnostic Laboratory
H07	Therapeutic Radiology
H08	Anesthesia
H09	Assistant at Surgery
H10	Other Medical Items or Services
H11	Used DME
H12	High Risk Screening Mammography
H13	Low Risk Screening Mammography
H14	Ambulance
H15	Enteral/Parenteral Nutrients/Supplies
H16	Ambulatory Surgical Center (Facility Usage for Surgical Services)
H17	Immunosuppressive Drugs
H18	Hospice
H19	Diabetic Shoes
H20	Hearing Items and Services
H21	ESRD Supplies

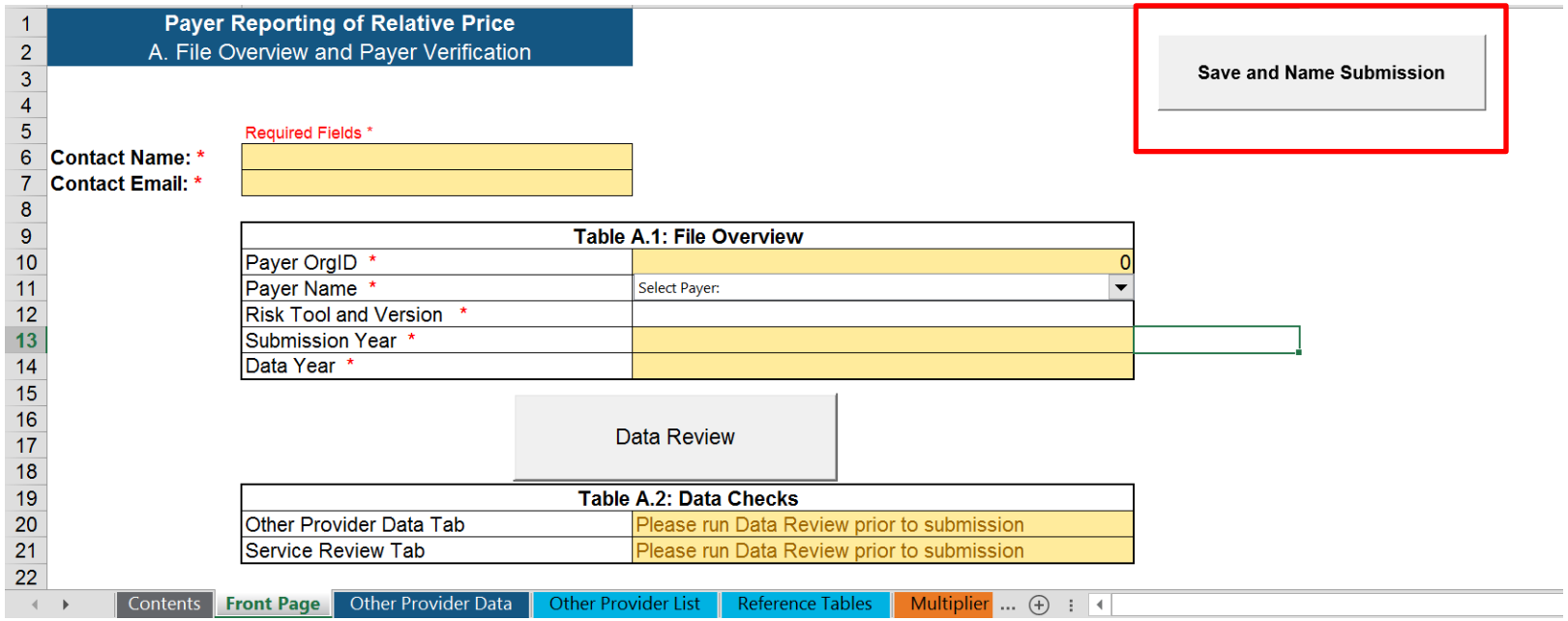
H22	Monthly Capitation Payment for Dialysis
H23	Kidney Donor
H24	Lump Sum Purchase of DME, Prosthetics, Orthotics
H25	Vision Items or Services
H26	Rental of DME
H27	Surgical Dressings or Other Medical Supplies
H28	Outpatient Mental Health Treatment Limitation
H29	Occupational Therapy
H30	Pneumococcal/Flu Vaccine
H31	Physical Therapy
X98	NonClaims
X99	Other/Multiple

**** Service Categories for RP derive from CMS Regulations and Guidance manual and from AAPC***

Appendix F: Submission Naming Conventions

The file naming convention will be automatically generated by clicking the "Save and Name Submission" button on the Front Page tab of the submission template. The file name will be similar to the file name shown below. The file can then be uploaded to the CHIA Submissions portal. Files that do not adhere to the automatically generated file name conventions will not be accepted for submission.

Save and Name Submission button:



The automatically generated file name will be similar to *"Payer_OrgID_147_2019_05042020123000_HOS_1234.xlsx"* – please do not change the file name from what is automatically generated. Files that do not adhere to the naming convention will not be accepted.

Appendix G: Reporting Non-Claims Payments in Hospital Outpatient, Physician Group, and Other Provider files

If payers do not allocate Non-Claims payments to specific services via an internal methodology, then payers should report Non-Claims Payments as its own service category named "NonClaims" in addition to the Claims Payments reported for individual service categories. See the table below for an example:

HospitalOrgID	HospitalTypeCode	InsuranceCategoryCode	ProductTypeCode	ServiceCategoryCode	Service	MultiplierIndicator	Multiplier	ClaimsPayments	NonClaimsPayments
999999	1	2	1	C3	Lab	1	2.0100	$ 150,000.00	$0.00
999999	2	3	1	H1	NonClaims	1	2.2200	$ -	$5,400.00
999999	1	2	2	H27	Surgery	1	1.4000	$ 54,096.00	$0.00
999999	2	3	2	C1	Office Visit	1	1.6000	$ 20,090.00	$0.00

Appendix H: In-Network vs. Out-of-Network reporting

Payers will indicate the number of providers that are considered In-Network and Out-of-Network. The yellow boxes listed below will allow each submitter to manually enter this information.

Table A.4: In-Network Providers (Inpatient)

					Hospitals		Percent of Payments	
Insurance Category	Product Type	Total Claims Payment	Total Non-Claims Payme	Number of Hospita	In Network	Out of Network	In Network	Out of Network *
Commercial	Indemnity	$100,000	$500	10	6	4	60%	40%
Commercial	Indemnity	$20,000						
Commercial	HMO	$10,000						
Commercial	HMO	$15,000						
Commercial	PPO	$80,012						
Commercial	Indemnity	$190,082						
Commercial	HMO	$38,000						
Commercial	HMO	$15,092						
Commercial	PPO	$100,800						